Instructions to Complete a Change of Address:

To notify the HR Office of a Change of Address, you may print the forms below, complete and return to the HR Office for processing. These forms include the following:

- Emergency Contact Form
- Health Insurance Change Form
- Life Insurance Change Form
- APERS Address Change Form

Please note: It is not necessary to complete a health and/or life insurance form if you DO NOT have health or life insurance coverage with the state. However, you must complete an emergency contact form and APERS form.

1) Completing the Emergency Contact Form: Please complete all sections of the form. It is important that you include updated allergies and medical conditions. In addition, we ask that you provide at least (2) contacts in case of an emergency.
2) Completing the Health Insurance Change form: Complete section 1 including all demographic information through your current work number. It is NOT necessary to complete your primary care physician information. Skip section 2 (does not apply to address changes). In section 3, check the "address" box. Under reason for change, select the "other" box and write "address change". Skip section 4. Sign and date at the bottom of the form.
3) Completing the Life Insurance Change Form: In Section 1, check the box at the top of the form by "employee address change". In section 2, complete name, employee number, home address, city, state, zip, social security number, date of birth, birth state, sex, marital status, home phone number, and work phone number. The other information either does not apply to your change, or is to be completed by the HR Office only. Skip sections 3, 4, 5, 6, & 7. Be sure to read section 8, sign and date at the bottom of the form.
4) Completing the APERS Address Change Form: Complete all requested information on the form. Please note the "effective date" is your effective address change date. Also, the agency should be listed as Secretary of State #063.

CHECK ALL FORMS FOR ACCURACY, PRINT, AND SEND TO THE HR OFFICE.

Emergency Contact Form:

This form should be updated each year. However, if you experience a mid-year change such as an address change, phone number(s) change, name change, medical change, or contact(s) information change, please submit a new emergency contact form to the HR Office.

Employees are reminded to contact the HR Office when you experience any kind of mid-year change. There may be other forms that are necessary to process your request.

SECRETARY OF STATE
EMPLOYEE EMERGENCY CONTACT FORM

Please complete the following information to be used in the event of an emergency.

Date Completed:_____

Employee Name	
Social Security Number	
Home Address	
City, State, Zip	
Home Phone Number	
Work Phone Number	
Work Cell Phone Number	
Personal Cell Phone Number	
Pager	
Work Email Address	
Birth Date	
Veteran (Yes or No)	
Smoker (Yes or No)	

Please list any medications or other substances you are allergic to:

Please list any medical conditions emergency personnel should be aware of:

Please list at least two people our office can contact in case of an emergency:

Contact Name:_____ Relationship:_____

Address:_____ City:_____ State:_____
Zip:_____
Home Phone Number:_____
Work Phone Number:_____
Cell Phone Number:_____

Contact Name:_____ Relationship:_____

Address:_____ City:_____ State:_____
Zip:_____
Home Phone Number:_____
Work Phone Number:_____
Cell Phone Number:_____

EBD Health Insurance Change Form:

Please complete form and return to the HR Manager to process your request. This form should be used for the following changes:

- To add or delete dependents from health insurance plan during open enrollment or during the plan year according to Cafeteria Plan rules which may allow a change in coverage status, i.e. Employee Only, Employee & Spouse, etc.
- To indicate the reason for making a change such as birth of a child, marriage, etc.
- To change mailing address or name.

PLEASE NOTE: Incomplete, illegible or otherwise unclear forms will be returned to you for correction and could possibly cause a delay in processing your request.

Section 1: Employee Information

Please provide the demographic information requested.

- If not previously provided, please print your email address if you would like to receive benefit updates and information mailed to you as the need arises.
- Primary Care Physician information is only required for members of the HMO or POS plans. DO NOT list a PCP if you are enrolled in the PPO plan.

Section 2: Change in Dependent Status

Complete this section if you want to add or delete a dependent from the plan.

- Provide complete information for each dependent.
- Please provide Social Security Number of the dependent, date of birth and whether the intent is to "add" or "delete" them from the policy.
- If dependents are being DELETED from the policy, it is not necessary to indicate PCP, PCP #, or Student Status. If you are ADDING a dependent, please complete all of the requested information.
- If dependent(s) is/are age 19 or older, they must be a full-time student to continue on the insurance. Please indicate whether they are a full-time student. You must also submit a Student Verification Form to the HR Manager. This form can be obtained in the HR Office, or you may download a copy via EBD's website at www.arbenefits.org. You will find the form on the Benefits Library Link.
- If applicable, please submit court orders for guardianship, court ordered insurance coverage or adoption papers for dependents being added to the policy.
- If you have more dependents than space allows, please attach an additional sheet containing the required information.

Section 3: Change in Coverage

Please complete this section to make any of the changes listed. Also provide a reason for the change, along with the date of the change.

- Address changes can be indicated as "other" for reason of change.

Section 4: To be completed by Agency

Do not complete this section. The HR Office will complete the information.

Employee Signature:

Sign and date the form on the lines provided. It is recommended that you make a copy of this form for you records.

! Don't forget to return the form and any necessary attachments to the HR Manager to be processed.

Note: if this change is for open enrollment, you must submit the form to the HR Office no later than October 31st. Changes will not take effect until January 1st.

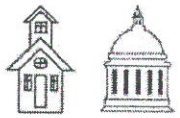
STATE OF ARKANSAS
Department of Finance
and Administration

EBD
Employee Benefits Division
Post Office Box 15610
Little Rock, AR 72231-5610

Phone: (501) 682-9656 Toll Free: (877) 815-1017 Fax: (501) 682-2366 www.state.ar.us/dfa/ebd

Change Form

Status, Name and Address



1. Employee Information: (please print)					
Last Name	First Name			MI	☐ Married ☐ Single
Home Address	City		State	Zip Code	
SSN#	Date of Birth:	Home #:		Work #:	
If you would like benefit information sent to you by email, please print your email address:					
Primary Care Physician:		PCP #		Current patient?	

2. Change in Dependent Status (complete this portion if making any changes in dependent status):			
FIRST NAME	LAST NAME	MI	GENDER
Social Security #	Date of Birth	☐ Add	☐ Delete
Primary Care Physician:	PCP #	Full time student?**	
FIRST NAME	LAST NAME	MI	SEX
Social Security #	Date of Birth	☐ Add	☐ Delete
Primary Care Physician:	PCP #	Full time student?**	
FIRST NAME	LAST NAME	MI	SEX
Social Security #	Date of Birth	☐ Add	☐ Delete
Primary Care Physician:	PCP #	Full time student?**	

*** Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.**
****For dependents 19 and over only. Please submit proof of student status.**

3. Change In Coverage (complete this portion if making any of the following changes):	
Change in Status:	Reason for Change:
☐ Employee Only ☐ Add Dependent ☐ Employee & Spouse ☐ Delete Dependent ☐ Employee & Children ☐ Name ☐ Family ☐ Address ☐ Cancel Coverage	☐ Birth - Date: _____ ☐ Death - Date: _____ ☐ Divorce - Date: _____ ☐ Marriage* - Date: _____ ☐ Other: _____

*** Please attach Marriage License; Maiden Name if applicable**

4. To Be Completed By Agency/School District:	
Agency/School District Name:	Agency/School District #:
Effective Date of Change:	Employee #:
Representative Signature:	Date:

Employee Signature: _____ **Date:** _____

Usable Life Insurance Application and Change Form Instructions:

This form may be used to make address or name changes, beneficiary changes, family status changes (allowed under Cafeteria Plan rules), and open enrollment changes.

PLEASE NOTE: Incomplete, illegible or otherwise unclear forms will be returned to you for correction and could possibly cause a delay in processing your request.

For an address or name change:

At the top of the form, check the box that indicates the type of change you are making (Employee Address Change). In the applicant information section, please provide the demographic information requested. Do not complete agency information, date of hire, or effective date of change. The HR Office will complete this information.

Please sign and date the back of the form in the authorization section as indicated. **Return the original form to the HR Office to be processed.**

*If making a name change, you must also submit a copy of your marriage license or court ordered document to validate the change.

For a Change of Beneficiary:

At the top of the form, check the box that indicates the type of change you are making (Beneficiary Change). In the applicant information section, please provide the demographic information requested. Do not complete agency information, date of hire, or effective date of change. The HR Office will complete this information.

Return the original form to the HR Office to be processed.

In the Beneficiary Designation/Change Section, please complete the following information:
Name of New Beneficiary, Address of Beneficiary, Birth Date of Beneficiary, Relationship of Beneficiary. You must also indicate whether the beneficiary is to be primary or secondary, and the Distribution, if necessary.

If no relationship exists, specify "friend".

All proceeds will be paid to the "primary" beneficiary, if living. A secondary beneficiary can also be named. In the event the primary is no longer living, the proceeds would be paid to the secondary beneficiary.

If the employee names more than one primary beneficiary, those who survive will share equally in the insurance proceeds unless the employee specifies otherwise on the application in the distribution column.

Examples of Standard Beneficiary Designations:

# of Beneficiaries	Name	Address	Birth Date	Relationship	Primary or Secondary	Percentage Distribution
(1) Beneficiary	Jones, Nancy M.	123 Main Street, Anytown, USA 12345	9/30/49	Wife	Primary	100%
(2) Beneficiaries	Jones, John L.	234 Main Street, Anytown, USA 12345	7/4/39	Father	Primary	50%
	Jones, Mary H.	234 Main Street, Anytown, USA 12345	3/20/41	Mother	Primary	50%
Secondary Beneficiaries	Jones, George H.	789 Main Street, Anytown, USA 12345	1/23/76	Child	Secondary	50%
	Jones, Richard E.	789 Main Street, Anytown, USA 12345	4/13/78	Child	Secondary	50%

For Family Status or Open Enrollment Changes:

Please contact the HR Manager to discuss these changes prior to completing the form. The type of event will determine which sections of the form must be completed and which can be omitted. In addition, depending upon the type of change, you may be required to submit documentation such as a marriage license, divorce decree, birth certificate, or death certificate.

Please note: most family status changes must be requested within 30 days of the event date. For open enrollment, all changes must be submitted by October 31st.

This form can be used for valid family status events such as marriage, divorce, and birth of a child. When these events occur, you can apply to add your spouse and/or child to the dependent coverage; or you can apply to drop your spouse and/or child from dependent coverage.

Return the original form to the HR Office to be processed.

USAble Life

P. O. Box 1650
Little Rock, Arkansas 72203-1650
(501) 375-7200 • 1-800-648-0271

Arkansas State Employees Life Insurance Application And Change Form

Home Office Use Only	
Eff Date	
AGENCY VERIFICATION	
Initials	

1. RETURN COMPLETED FORM TO YOUR AGENCY INSURANCE REPRESENTATIVE.

☐ New Coverage	☐ Increase Supplemental Life Amount	☐ Drop All Employee Life Coverage
☐ Beneficiary Change	☐ Decrease Supplemental Life Amount	☐ Drop All Supplemental Life Coverage
☐ Add Dependent Life	☐ Increase Optional Dependent Life Amount	☐ Drop All Dependent Life Coverage
☐ Employee Name Change	☐ Decrease Optional Dependent Life Amount	☐ Drop All Optional Dependent Life Coverage
☐ Employee Address Change	☐ Termination of Employment - (Date of Termination _____)	
☐ Agency Change		

2. APPLICANT INFORMATION

Employee Name (Last, First, M.I.)					Employee #		Group # 6730
Home Address Street		City		State	Zip		Social Security #
Date of Birth	Birth State	Sex	☐ Male ☐ Female	Height (ft.-in.)	Weight (lbs)	Marital Status	Home Phone #
Agency Name		Agency Number		Date of Hire			Work Phone #
Complete if making an Agency Change		Old Agency Name			Old Agency Number		Eff. Date of Change

3. SPOUSE AND CHILDREN INFORMATION (COMPLETE IF APPLYING FOR DEPENDENT COVERAGE.)

List ALL Dependents To Be Covered For One Or More Unit(s) of Dependent Life Insurance.
Dependents NOT Listed Will Not Have Coverage.

Person Proposed for insurance Show first, middle, last name	Relationship	Date of Birth & Place				Height	Weight	Marital Status	Sex
		Mo.	Day	Yr.	State or Country				

4. BASIC LIFE COVERAGE ($10,000 coverage PAID for by the State of AR)

I hereby apply for the following Basic Life Coverage (if not currently enrolled):

☐ Employee $10,000 (Paid for by State of AR)	☐ Legislators and Constitutional Officers $10,000 (Paid for by State of AR)	☐ Legislators and Constitutional Officers Basic Life of $30,000

☐ DECLINATION - I do not wish to participate/continue under the State Employees' Group Life Plan. I understand that I will have to furnish proof of good health if I apply at a later date.

5. SUPPLEMENTAL LIFE COVERAGE

5a. For Employees, Legislators & Constitutional Officers

Annual Salary from State of Arkansas

$_____

I hereby apply for:

☐ 1 times my annual salary rounded to next higher $1,000 = $_____

☐ 2 times my annual salary rounded to next higher $1,000 = $_____

5b. For Dependents of Employees

Unit(s)/Insurance Amount

☐ 1 Unit - $4,000
☐ 2 Units - $8,000
☐ 3 Units - $12,000
☐ 4 Units - $16,000
☐ 5 Units - $20,000

5c. For Dependents of Legislators & Constitutional Officers

Unit(s)/Insurance Amount

☐ 1 Unit - $20,000
☐ 2 Units - $40,000

6. BENEFICIARY DESIGNATION /CHANGE

This will revoke any existing beneficiary designations you may have under these benefits.

Name (Last, First, MI)	Address	Birth Date	Relationship	Primary or Secondary	Percentage Distribution*

* Death Proceeds will be paid to the Primary Beneficiary(ies) if living, otherwise as specified above to the Secondary Beneficiary(ies).

PLEASE COMPLETE AND SIGN PAGE 2/REVERSE SIDE.

Name (First, MI, Last)	Social Security #	Employer

7. MEDICAL INFORMATION

Note: This information is only needed when adding or increasing coverage.
Complete the information below on all persons applying for coverage (applicant and/or dependents).

1. Have you, your spouse or children been hospitalized for any reason during the past five (5) years? ☐ Yes ☐ No
If yes, give date, name of person(s), and reason hospitalized:

_____

_____

2. Have you, your spouse or children consulted a physician in the past one (1) year? ☐ Yes ☐ No
If yes, give name of person(s), names of doctors seen, and reason:

_____

_____

3. Have you, your spouse or children ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? ☐ Yes ☐ No If yes, list name of person(s), medications taken, medication dosage, and last two blood pressure readings.

_____

_____

4. Have you, your spouse, or children ever been diagnosed by or received treatment from a member of the medical profession for:

	Yes	No		Yes	No
a) Cancer or any cancer related disease?	☐	☐	e) Alcohol or Drug Abuse?	☐	☐
b) Disease of the heart or blood vessels, or had a stroke?	☐	☐	f) Lung, Liver or Blood Disorder	☐	☐
c) Kidney disease or diabetes?	☐	☐	g) Emotional, Nervous System or Mental Health Problems?	☐	☐
d) AIDS or AIDS Related Complex, Immune Deficiency Disorder, or tested positive for antibodies to HIV?	☐	☐			

GIVE DETAILS TO ANY "YES" ANSWERS TO QUESTION 4 above, including name of person, diagnosis, and dates of treatment:

_____

_____

5. Do you, your spouse or children have any impairments, diseases or illnesses not covered in questions 1 through 4?
☐ Yes ☐ No If yes, give details, including name of person, diagnosis, and dates of treatment:

_____

_____

6. Are you, your spouse or children currently taking medication(s)? ☐ Yes ☐ No If yes, give name of person, medication(s), dosage, and reason for taking medication(s):

_____

_____

7. Name, address, and phone number of personal physician(s):

_____

_____

8. Have you, your spouse or children ever been declined coverage under this Plan? ☐ Yes ☐ No Any other plan? ☐ Yes ☐ No

8. AUTHORIZATION SECTION

In signing below, I (a) represent that the statements and answers given in this application, both front and back, are true, complete and correctly recorded to the best of my knowledge and belief; (b) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc., having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (c) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (d) agree that this authorization shall be valid for two (2) years from the application date; (e) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (f) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act; and (g) acknowledge receipt of the Insurance Fraud Warning. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void this policy.

Insurance Fraud Warning - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

DATE OF APPLICATION _____ _____
MONTH/DAY/YEAR EMPLOYEE'S SIGNATURE

RETURN COMPLETED FORM TO YOUR AGENCY INSURANCE REPRESENTATIVE.

ARKANSAS PUBLIC EMPLOYEES RETIREMENT SYSTEM
ONE UNION NATIONAL PLAZA
124 WEST CAPITOL
LITTLE ROCK, AR 72201
IN PULASKI COUNTY (501) 682-7800
OUTSIDE PULASKI COUNTY 1-800-682-7377

NOTICE OF CHANGE OF ADDRESS

AGENCY _____ EFFECTIVE DATE _____

The following employee requests a change of address on agency personnel records. The new address should be used for administration and personnel purposes.

PLEASE PRINT LEGIBLY

EMPLOYEE'S NAME
_____

SOCIAL SECURITY NUMBER _____ -_____ -_____

NEW ADDRESS:

_____
Street **Apt. or Box No.**

_____
City **County** **State** **Zip Code**

_____ _____
Home Phone **Work Phone**

_____ _____
Signature **Date**